City of El Paso

Human Resources Department

Non-Uniform Accident with Pay Leave Request

PART I – EMPLOYEE'S REQUEST (Type or Print in Ink)

To: **DEPARTMENT HEAD** DEPARTMENT:

From: (EMPLOYEE LAST, FIRST, MIDDLE INTIAL) Kronos #:

Under the provisions of Section 4.4, City Ordinance 8064 (Amended 03/06/12), I hereby request Accident With Pay Leave. This request is based upon my job-related injury or occupational disease which occurred on_____(date) at _____M (time). I reported my injury or occupational disease to supervisor _____(name) on _____date) at _____M (time). I have attached the required medical report from my treating physician indicating that any lost time is due to my job-related injury occupational disease. I understand that I must request AWP leave for each additional period of absence, and must provide a medical report for the corresponding amount of days or hours of AWP leave requested with each AWP Leave Request.

I understand that for the initial (7) days of lost time, I will not receive AWP leave I ELECT/DO NOT ELECT **(circle one) to use my accrued sick leave/annual leave during the initial seven days of disability. I further understand and agree that in the event of any overpayment of workers' compensation benefits or AWP supplement, the City may deduct the overpayment from future wages or reduce any accrued leave balances.**

Employee Signature: Date:

PART II – DEPARTMENT HEAD'S RECOMMENDATIONS

To: HUMAN RESOURCES DIRECTOR

From: DEPARTMENT HEAD'S NAME : DEPARTMENT:

_____

Department Head Signature DATE:

Recommend **DENIAL** of AWP leave: ☐ Based upon the following reason(s) – check applicable box(es):

☐ 48-hour reporting requirement not met.

☐ Physician's report not submitted.

☐ Violation of rule/regulation/law/City safety rule/Dept. mandated procedure/Failure to use safety equipment._____

☐ Other (indicate other reasons for denial): _____

GIVE A COPY OF THIS TO THE EMPLOYEE:

Department Head or Designee Signature DATE:

PART III – HUMAN RESOURCE DIRECTOR'S APPROVAL/DENIAL

APPROVAL ☐ of AWP Leave **DENIAL** ☐ of AWP Leave

Human Resources Director Signature DATE:

A. IN PERSON

EMPLOYEE"S SIGNATURE : DATE:

B. BY CERTIFIED MAIL:

CERTIFIED MAIL RETURN RECEIPT REQUEST NUMBER: DATE:

If your AWP Request is denied by the Human Resources Director in Part II above, you have FIVE (5) calendar days from the date of receipt of this form to appeal to the Human Resources Director.

02/25/2013